

Abstract

The growing presence of women Veterans in Veterans Health Administration (VA) settings has prompted the need for greater attention to clinical proficiency related to women's health (WH) primary care needs. Instead of making appointments for multiple visits or referring patients to a women's health clinic or alternate site for gender-specific care, a comprehensive primary care model now allows for women Veteran patients be seen by primary care providers (PCPs) who have WH training/experience and can see them for both primary and WH care in the context of a single visit. However, little is currently known about the barriers and facilitators WH-PCPs face in using this approach to incorporate gender-specific services to women Veterans' primary care needs. We conducted qualitative in-depth interviews with 22 WH-PCPs at one Midwestern VA Medical Center. All participants were members of one of four outpatient primary care clinics within the main medical center, one off-site satellite clinic, or two off-site community-based outpatient clinics (CBOCs). Inductive thematic analysis identified six themes: 1) time constraints, 2) importance of staff support, 3) necessity of sufficient space and equipment/supplies, 4) perceptions of discomfort among patients with trauma histories, 5) lack of education/training, and 6) challenges with scheduling/logistics. Although adequate staff was a key facilitator, the findings suggest that there may be barriers that undermine the ability of VA WH-PCPs to provide high quality comprehensive primary and gender-specific care. The nature of these barriers is multi-factorial and likely multi-level in nature, and may therefore require special policy and practice action.

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Introduction

Women Veterans are projected to comprise over 12 percent of the total Veteran population by 2020 according to the Department of Veterans Affairs (Department of Veterans Affairs, 2013). Although there has been an 80% increase in the number of women Veterans using VA healthcare system over the past decade, they are still a numerical minority, comprising 6.5% of VA healthcare users (Frayne et al., 2014). To accommodate the growing number of women VA users, and to address historical gender disparities and gaps in quality of care for women Veterans, (U.S. Government Accounting Office, 1999; Washington, Kleimann, Michelini, Kleiman, & Canning, 2007; Washington, Yano, & Simon, 2006b) a national model of comprehensive primary care (i.e., both gender-specific care and general primary care) has been developed and disseminated (Mengeling, Sadler, Torner, & Booth, 2011; Seelig, Yano, Bean-Mayberry, Lanto, & Washington, 2008).

Comprehensive care models in general have the potential to address the fragmentation that has been evident in routine preventative and/or chronic disease management and reproductive health services, for which women have commonly been expected to make separate appointments with separate physicians and separate copayments (Weisman, Chuang, & Scholle, 2010). This is particularly important given the bimodal distribution of the women Veteran population that is emerging, comprised of an older cohort as well as a growing young women Veteran population of child-bearing age (Frayne et al., 2014). Within and outside the VA, comprehensive care models are associated with higher ratings of patient satisfaction and quality of care (Anderson et al., 2002; Bean-Mayberry et al., 2003). Studies have also shown that women Veterans prefer to receive comprehensive care from one physician or within one clinic (Washington et al., 2007; Washington, Yano, & Simon, 2006a).

VHA updates in policy (VHA Handbook 1330.01, May 2010) now recommend that all women Veterans have the opportunity to receive both primary care and women's health (WH) services (e.g., Pap smears, breast exams, contraception counseling, and menopause treatment) by one WH-PCP in the context of a single visit, and irrespective of the setting (e.g., a VA medical center or community-based outpatient or independent clinic). In order to be designated as a WH-PCP, along with meeting various proficiency requirements, a provider's panel has to be comprised of at least 10% female patients, or the provider has to practice or precept at least one half day a week or more in a women's health practice (VHA Handbook 1101.10, 2014).

Women Veterans have unique conditions, issues, and disease symptoms (e.g., gynecological care, domestic violence screening, family planning, pregnancy, postpartum depression, chronic pelvic pain, and menopause), compared to male Veterans, and have higher rates of some mental health disorders (Haskell et al., 2011). In addition, women Veterans have higher rates of military sexual trauma (MST)¹ and also may have deployment-related issues that would not be seen among civilian women, including combat exposure (Goldzweig, Balekian, Rolon, Yano, & Shekelle, 2006). At the same time, there has been little to no research on providers' experiences in delivering care to women Veterans, and prior research has pointed to potential gaps in PCP knowledge (Yano et al., 2011).

Because VA healthcare delivery has historically focused on male Veterans' healthcare needs, what remains unclear are the barriers and facilitators WH-PCPs encounter in their roles in light of the unique and potentially challenging clinical issues that women Veteran patients might present. Furthermore, in the comprehensive care model, WH-PCPs face additional requirements

¹ MST is VA-specific terminology (taken from Federal law Title 38 U.S. Code 1720D) that refers to any type of sexual activity (spanning sexual assault or repeated, threatening acts of sexual harassment) a Service member was involved in, during active duty or active duty for training, that was against the person's will.

in terms of procedures, staffing, and time (e.g., safety requirement for a chaperone during gender-specific exams, one-hour instead of 30-minute visits for women Veterans who also need Pap or pelvic exams to be conducted, etc.). The purpose of this study was to examine these issues through in-depth qualitative interviews of WH-PCPs.

Methods

Study Design, Setting and Sample

Qualitative in-depth interviews were conducted with WH-PCPs at the Roudebush VAMC in Indianapolis, Indiana at one point in time by the lead author (AB) and a trained research assistant. Data collection took place from 06/2012-02/2013. All participants were members of one of four outpatient primary care clinics within the main medical center, one off-site satellite clinic, or two off-site community-based outpatient clinics (CBOCs). In order to enhance delivery of comprehensive primary care to the nation's Veterans, primary care at VAs around the country also launched a patient-centered medical home model in 2010, called Patient-Aligned Care Teams, or PACT. PACT involves the delivery of care by "teamlets," ideally comprised of a full-time-equivalent PCP, registered nurse care manager, licensed vocational or practical nurse, and clerk, in a 3-to-1 staffing ratio. All PCPs in this study were members of PACT teamlets.

At the Roudebush VAMC, a Women's Comprehensive Health Care Implementation Plan was rolled out in 2009, with the goal of delivering comprehensive primary care to all women Veteran patients by 2014. To date, VA PCPs who are both interested and proficient in women's health have been given a designation of WH-PCP, and VA PACT guidelines recommend additional time for comprehensive visits that involve Pap and pelvic exams, along with a decrease in patient panel size to adjust for such time requirements.

We recruited from the population of 32 WH-PCPs (spread across the four outpatient primary care clinics within the main medical center, one off-site satellite clinic, or two off-site CBOCs). After obtaining informed consent, face-to-face semi-structured interviews were conducted by the first author and a research assistant trained in interviewing methods. Interviews were conducted prior to, during, or after the participant's shift in a private VA interviewing room. Participants were not compensated. All procedures were approved by the Indiana University and Roudebush VAMC Institutional Review Boards. In addition, we received permission from the employee union as well as local VA administration (e.g., Chief of Primary Care, Chiefs of each clinic) before recruitment began. Several Clinic Chiefs sent an email notifying their PCPs that they would be contacted for recruitment in a voluntary study.

Some of the key questions in the interview guide included the following: (a) Please tell me what your experience has been like so far being a comprehensive women's health provider; (b) How difficult or easy is it to do Pap smears at the VA?; (c) I'd like to hear an example of a challenge you've encountered with regard to giving women's health care since you've become one of the designated providers; (d) What about a success or accomplishment related to giving women's health care? All interviewees were asked the same open-ended questions, with both pre-specified probes and spontaneous follow-up or probing questions depending on the participant's initial responses. A complete list of interview questions are included in Appendix A. Interviews lasted between 19 and 54 minutes ($M=30.1$). Data collection took place from 06/2012-02/2013. All interviews were professionally transcribed verbatim.

Analysis

We conducted qualitative thematic data analysis using the constant comparative method (Charmaz, 2006) in order to identify emerging patterns and themes that resulted from the open-

ended questioning format used in the interviews. There were no pre-defined categories into which responses were grouped, but instead an inductive process allowed salient categories of meaning to emerge from the interview data. Using a consensus-based approach, the first author and another research team member with expertise in qualitative analysis reviewed each transcript as soon it became available. In the first phase of coding, each segment, sentence, or phrase was examined for ideas or thought units which led to the creation of an iterative-based code list. Agreement was established for all codes and subcodes for each transcript. Next, the most frequent and significant initial codes that emerged across all of the transcripts (e.g., positioning of beds, availability of exam rooms) were then organized together to form categories from which the substantive themes emerged (e.g., the key barriers or challenges faced by WH-PCPs such as space and structure).

Results

Participants

Twenty-two of thirty-two (69%) eligible designated WH-PCPs participated in the interviews (14 female, eight male; 17 physician PCPs, five nurse practitioner [NP] PCPs; 17 White, four Asian, one African American). The participants had worked for an average of 6.6 years as a PCP in the VA, and roughly 2 years on average with the official designation of WH-PCP. However, some had functionally provided WH services for much long during their VA PC tenure (and before the creation of the WH-PCP designation). Although WH-PCPs in three out of the four primary care clinics in the main medical center were well-represented in the sample, we were successful in recruiting only one of several WH-PCPs in the fourth clinic. Seven of the 22 WH-PCP participants worked at either the satellite clinic or CBOC clinics, with at least two WH-PCPs from each location. Participants had practiced in the VA for an average of 5.5 years.

Emergent Themes

Six themes emerged regarding WH-PCP provision of comprehensive care to women Veterans: 1) time constraints, 2) importance of staff support, 2) necessity of sufficient space and equipment/supplies, 4) perceptions of patient discomfort, 5) lack of education/training, and 6) scheduling/logistics. The themes are reported in the order of the frequency with which they were discussed among participants. It is important to note that many of the themes were interconnected (e.g., when the supplies were lacking, time constraints were exacerbated), and not mutually exclusive, as WH-PCPs often cited several of the above issues.

Time Constraints: Despite VA recommendations that WH-PCPs take 60 instead of 30 minutes for appointments that included Pap or pelvic exams, there was a general lack of awareness and/or practice of this guideline among the participants. Many discussed how in their experience, 30 minutes was not sufficient to address women Veterans' primary care needs, chronic pain, mental health, and military sexual trauma (MST) issues, along with gender-specific care. Women Veterans were often described as inordinately complex patients who present with multiple, time-consuming physical and mental health **comorbidities that needed to be managed**. As a result of such perceived time constraints, one participant reflected on some of the unintended consequences:

Our visits are half an hour long, and in a visit that's intended to provide all women's health care in a single visit, the woman comes with multiple issues to discuss [and] at the end you're expected to do a Pap smear, which takes an additional ten to fifteen minutes. And so sometimes you just run out of time. Sometimes I am forced to just do a gynecology consult just for timing.

Because the VA requires the presence of a female chaperone in the exam room while WH-PCPs conduct Pap or pelvic exams (regardless of WH-PCP gender), another difficulty identified by WH-PCPs was the burden of time needed to search for a chaperone, along with time to look for equipment and/or wait for patients to get undressed and dressed again. One provider explained:

So right now what happens is you just kind of hope for the best and realize that if you're doing a Pap smear you're going to be behind the rest of the day unless you have a no-show patient or something.

Many WH-PCPs also described women Veterans as more communicative than male Veterans, which further compounded the problem of time:

Even if it's a straightforward woman, she is still more chatty than your average guy ... if a woman is coming into my clinic and she says, 'I'm depressed,' she wants to talk for five minutes about how she feels. A man says, 'I think I'm depressed,' and that's all he wants to say about it....

Importance of Staff Support: The presence or absence of the right kind of staff support (e.g., staff who are available, competent, comfortable and willing to provide assistance with Pap or pelvic exams) for many participants determined whether clinic-specific comprehensive care processes broke down or succeeded. For instance, insufficient numbers of support staff resulted in last-minute binds:

Yesterday we were scrambling around to try to do a pelvic exam on a patient because all the nurses had left except one and it was an RN and she was trying to admit a patient, a man whose blood sugar was 700, and then we come to her with, 'You're the only female...'

In addition, some participants described instances of staff refusing to assist with Pap and pelvic exams. One PCP said,

On the occasion when I'm asking a nurse, 'Can you help me?' [gather the necessary equipment for a Pap], and [I hear] 'No,' is that really the answer or is it just that they haven't worked out in the nursing flow and I was asking the wrong nurse?"

Even among those staff members who willingly offered assistance, one WH-PCP explained, "If you want to do any testing, they're [support staff] not very sure of what you need and things like that."

Conversely, other participants attributed easy and well-integrated experiences with providing WH care to good staff assistance. They emphasized the invaluable role staff played in facilitating Pap and pelvic exams in particular, as described by the following individual from a CBOC site:

My nurse and I have a good flow. She knows what to get out for me and has it ready and available. I put the order in. I print it off. I put it in the bag when it's finished ... So we have a PACT system and it's really nice ... the whole thing is a lot easier when everybody's in tune and knows what needs to be done.

Another participant at a CBOC site also noted:

You wanna get it [Pap] done that day we'll bring in an LPN, she'll talk to you, disrobe you; she'll come back in next time with me. And then obviously she knows what I need, so everything I need is on the tray. Everything is in the building. And she just puts it on the tray. I do it, and I'm done.

In fact, almost all of the WH-PCPs from the satellite clinic and CBOCs reported that delivering gender-specific care was easy due to effective staff support. Having previously worked at the main medical center, a participant from the satellite clinic drew a contrast:

At this clinic [it is] a lot easier than at the main hospital ... pretty much our LPNs have everything set up. We have our own Pap cart. When I came here, the staff was familiar with how to set things up and make it really smooth... it [doing Paps] seems to happen more often, so people are just more familiar with the routine of getting everything set up and doing the test and ordering.

Necessity of Sufficient Space and Equipment/Supplies: Many WH-PCPs perceived an insufficient number of rooms to conduct Pap and pelvic exams, with available rooms having an awkward layout or not being equipped with the necessary supplies (e.g., Pap smear kits being stocked elsewhere due to a lack of space). For Pap or pelvic exams, the positioning of exam room tables presented a two-sided challenge. For instance, due to privacy concerns, many PCPs felt uncomfortable with the foot of the bed positioned towards the door in the event that it might be opened during the exam. At the same time, for others, having the foot end of the bed facing away from the door rendered some exam rooms useless because there was not sufficient room for them to move around.

Other issues of space related to rooms in general (including waiting rooms) lacking privacy, though considerable variation existed across clinics. One participant expressed frustration at how exam rooms were not set up to facilitate providing Pap smears and pelvic exams:

We aren't a clinic that's set up to do a Pap. Like for instance, you go to your gynecologist, they do Paps for almost every patient that they see, and so they just are

efficient in doing it. They've just got everything down, the thin prep that the cells are used in, the liquid. That's all in the room already ... all the provider has to do is just pull it out of a drawer and it's all present.

Perceptions of Patient Discomfort: Perceptions of patients' level of comfort in receiving gender-specific care was described at length and in detail by some participants as a barrier to delivering comprehensive care. The biggest challenge was the high prevalence of patients with trauma histories such as military sexual trauma (MST). Some providers believed that patients who had a background of MST would be uncomfortable with getting Pap or pelvic exams from a male WH-PCP or when the patient-provider relationship was new or recently established, or would prefer additional privacy and male-free spaces that the primary clinic could not provide:

Our waiting room [prior to a pelvic exam] may not be the most gender-friendly and some female veterans may be intimidated, especially if they suffer from any military sexual trauma, so they may be less comfortable sitting in a waiting room full of twenty guys. There were a few WH-PCPs who even avoided or delayed giving or addressing gender-specific care or issues with their women Veteran patients due to these assumptions regarding MST (e.g., patient preferences for provider gender, readiness, etc.) One PCP was not yet giving Paps to women Veteran patients, but described the difficulties that might be encountered with those who have MST histories: "Especially getting them the preventative [Pap] thing, that they might not be willing to do that with the history of female MST. ...And you can't be doing a pap on somebody who's, you know, emotionally disturbed."

Finally, a few participants perceived that women Veterans (and women in general) prefer female providers giving them their breast, Pap, or pelvic exams. One WH-PCP said, "Some

patients don't want male providers to do their Paps." And another explained, "It's a sensitive exam ... I think many women really, they would prefer a woman doing the exam. That's somewhat speculative, but I think there's some truth to that."

Education and Training: Although some providers were satisfied with what the VA offered in terms of women's health training and education, others felt as though they were not given sufficient educational resources (e.g., continuing medical education geared more towards nurses or nurse practitioners), or did not have the opportunity to perform gender-specific exams or procedures frequently enough (e.g., through an ongoing local educational process, post training) in order to keep up their skills. For instance, PCPs are offered a VA Women's Health Mini-Residency Program comprised of 18 hours of gender-specific health care didactics and hands-on training (e.g., therapeutic options for menopausal symptoms, proficient performance of breast and pelvic exams, etc.), but some participants still had concerns:

I was sent to a women's kind of mini-residency program ... it seemed more like it was a check-off, like if you're a designated provider you must go to the women's mini-residency and so I did that and so that box was checked off, and it's like now what?

Another issue was the frequency of mini residency opportunities and how fast they filled up.

One participant discussed the additional option of periodically embedding oneself in the local women's health clinic for a day, but pointed out that taking advantage of such opportunities (in addition to the mini residencies) is difficult because there is no time or coverage provided, and a PCP can lose up to 14 patients in one day if there is not a surrogate provider. Other concerns included uncertainty regarding what WH training was required and what was optional for designated WH-PCPs (and how many hours of women's health continuing medical education they were required to complete), and a few wished there were feedback mechanisms in place

after training to let them know how well they were or were not doing related to their WH program.

Some providers also mentioned specific areas in which they would like to see more women's health training offered, such as menopause and incontinence care, and conducting Paps on patients who are obese (e.g., locating the cervix). Finally, one participant discussed the importance of incorporating more patient-provider communication and interaction skills into the women's health education for PCPs: "I think the VA's focused a lot on providing medical resources and training and things.... So I feel like we've covered the medical knowledge part reasonably well, but it's the doctor-patient communication side of it that's probably harder to teach and is going to be a little more difficult to pick up."

Scheduling/Logistics: Some participants also mentioned scheduling and logistical barriers to plan ahead for Pap smear and pelvic exam appointments or to adjust to patient cancellations due to the timing of menses. In addition, others explained how for women Veteran patients, there was no specific information included in the appointment reminder letter that the upcoming appointment would include a Pap. PCPs, in turn, did not realize that a Pap or pelvic exam would be conducted until it popped up as a clinical reminder. One participant described an idea for improving the process:

If I were going to design it ideally, the patient would get a letter that says, 'We're going to be doing your Pap smear', so that they come in with that expectation. If you had an appointment type that was 'annual Pap smear' or 'gynecologic exam', everybody could plan for it....

At one of the CBOC sites, a WH-PCP described a successful local innovation where one staff member was specifically assigned to the task of providing both patients and PCPs advance notification.

Discussion

We uncovered both challenges to and facilitators of the delivery of comprehensive primary care for women Veterans, including: challenges related to time constraints, the importance of staff support, significance of adequate space and equipment/supplies, perceptions of patient discomfort with gender-specific care, a lack of WH education or training (including updates and refresher courses), and the need to improve appointment scheduling and logistics. WH-PCPs appeared to be especially concerned about handling women Veterans' multiple comorbidities under existing time constraints, with most of the participants indicating that 30-minute visits was insufficient especially if gender-specific care was also needed. Although the VA has proactively worked to address the issue of time by recommending one-hour visits for women Veterans in which Pap smears and/or pelvic exams also need to be conducted, it appears, at least from our data, that these recommendations were not being fully implemented at the local level.

The importance of availability, consistency, and cooperation/buy-in of support staff was highlighted; for many, difficulties with obtaining adequate staff support to facilitate Pap smears and pelvic and breast exams was a key barrier to providing comprehensive care. However, when such support was readily available, it was seen as a key facilitator. In contrast to the general PC clinics within the medical center, participants from the satellite clinic and CBOCs reported well-functioning staff support. It is possible that the absence of onsite women's clinics in the sites other than the main medical center resulted in increased self-reliance to develop smooth

workflow and consistent team processes and approaches to gender-specific care. At the same time, such findings may reflect a smaller and more cohesive staff size at these sites (and thus fewer training sessions required) as compared to larger medical centers, and a smaller number of WH-PCPs that have increased awareness of their unique role expectations and processes related to gender-specific care.

These findings may have particular relevance for VA's PACT teamlets in terms of continuing to develop best practices for WH-PCPs to communicate needs and pre-allocate routine tasks to support staff (e.g., getting the speculum and other supplies ready for a Pap smear, serving as or finding a female chaperone, etc.) in both newly developed and more well-established PACTs. It might also be valuable to have contingency plans in place for times when those staff members with whom WH-PCPs work with most closely are out sick, on vacation or otherwise occupied. Recent research has also noted the challenge of cross-coverage in teamlets and highlighted the need for clear cross-coverage policies in order to improve PACT implementation (Rodriguez et al., 2014).

Additionally, more frequent course offerings in women's health education along with the assurance of surrogate provider coverage in order to attend such trainings can assist PCPs with keeping skills up-to-date. When appointment scheduling for comprehensive care visits presents difficulties, developing innovative IT solutions (e.g., an appointment type of "annual Pap smear" or "gynecological exam" to plan ahead), and dissemination of local clinic innovations for improving such workflow processes (e.g., staff dedicated to giving both patient and WH-PCP advance notification) will be important. Finally, enhancements in VA leadership communication and administrative support to WH-PCPs and staff may also be necessary in order to effectively

overcome some of these barriers, particularly those related to awareness of longer appointment times, problems with scheduling and/or resources, and support for Pap testing.

The adequacy of VHA space for delivering appropriate care to women Veterans (while also sufficiently attending to their privacy needs) has been a problem in the past (U.S. Government Accounting Office, 1999). Increased attention to this dilemma has led to the development and greater diffusion of women's health clinic models (Yano, Goldzweig, Canelo, & Washington, 2006), but little has been reported about changes in space and privacy for women Veterans. The continued growth in numbers of women Veterans patients seeking care in VA facilities will likely promote decision-makers to invest in space and, in particular, to ensure that a sufficient number of rooms are available for WH-PCPs to conduct pelvic exams and other gender-specific procedures.

Fortunately, limitations related to a lack of equipment or stocking of supplies are easier to overcome than retrofitting or converting physical exam room space. Additional creative solutions spanning all types of VA clinics can be identified and shared (such as the use of "Pap carts" as described by one WH-PCP study participant). We anticipate that the space, structure, and supply problems may be more prominent in VA than non-VA settings, but there is a dearth of information about the extent to which other general primary care clinics adequately address women's comprehensive care needs (Clancy & Sharp, 2013).

The perceived discomfort of women Veterans (especially those with a background of MST) was another factor that impacted the delivery of comprehensive care by WH-PCPs, with some participants delaying or avoiding the provision of gender-specific care due to the possibility that patients had an MST background or related trauma sensitivities. Because the recommended frequency for Pap tests is higher for younger women (i.e., under age 30), it is

particularly concerning that VA PCPs lack guidance on how to deliver gender-specific care that is “trauma-sensitive” (e.g., sensitive approaches to communication and rapport, sharing information and control, respecting boundaries, demonstrating awareness and knowledge of trauma (Ligenza, 2012)), given a high prevalence of MST among WVs using VA care (Department of Veterans Affairs, 2014), and greater numbers of WVs of childbearing age entering the VA (Frayne et al., 2014).

There were several limitations to this study. Although we did not identify any pattern related to differences in responses based on the type of WH-PCP (i.e., physician or NP), it is possible that the representation of additional participants from the fourth PC clinic (who were mostly male) may have allowed us to otherwise uncover differences based on site and gender. Another limitation was the inability to compare and contrast unique differences between sites, (e.g. CBOC, satellite, and medical center) with regard to the themes that we uncovered.

Implications for Practice and/or Policy

There is growing recognition that women Veterans with MST histories may require different approaches to care, such as increased sensitivity during patient-provider encounters (e.g., communication style, approach to the physical exam) and supportive care coordination (U.S. Department of Veterans Affairs, 2013). Indeed, prior research has documented a link between sexual violence and reactions of distress and anxiety during pelvic exams not only for women Veterans (Lee, Westrup, Ruzek, Keller, & Weitlauf, 2007; Weitlauf et al., 2008) but for women in the general population as well (Hilden, Sidenius, Langhoff-Roos, Wijma, & Schei, 2003; Leeners et al., 2007).

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Previous research on male Veterans has emphasized the importance of eliciting preferences for provider gender based on the circumstances of the prior MST experience/s (Turchik et al., 2013), and the same likely applies to women Veterans. It will be beneficial to identify processes, particularly for male WH-PCPs, to determine provider gender preferences among women Veteran patients (with or without MST histories) in order to prevent assumptions and minimize possible associated delays or referrals for gender-specific care.

The findings of this study (and the future research directions to which they point) have relevance to PCPs both within and outside the VA healthcare system because there is there growing attention more generally to the challenges related to provider proficiency in the provision of exams and procedures for those patients with trauma histories (Ligenza, 2012). Approaches to gender-sensitive care may be useful to women with sexual trauma histories, including MST, but also traumas occurring before or after military service.

In addition, because an only estimated 15% of women Veterans utilize the VA healthcare system (Department of Veterans Affairs Office of Policy and Planning, 2008; Hayes & Krauthamer, 2009), healthcare providers in community clinics in the US should be prepared to handle the unique healthcare needs of women Veterans patients, including approaches to handling gender-specific care for those who have MST histories.

Women Veteran patients have complex healthcare needs (e.g., multiple comorbidities, high rates of MST, gynecology and menopause-related care, etc.) that can be addressed through improved comprehensive health care services within the VA system (Haskell et al., 2011). Because VA's workforce has limited historical exposure to female patients, the VA may face special challenges in overcoming some of the identified barriers related to comprehensive care.

The nature of these barriers is multi-factorial and likely multi-level in nature, and may therefore require special policy and practice action.

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